		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036921

Facility Name: S.T.R.I.V.E.

Address: 415 A STREET (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: 815-537-5358 **Fax #** 815-537-2328

IDPA ID Number: 23-7136038003

Date of Initial License for Current Owners: 4/09/1991

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/2003 to 6/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ALAN GAPINSKI
(Title) CEO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 16

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,400			5,400	13
14	TOTALS	5,400			5,400	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.21%

D. How many bed-hold days during this year were paid by Public Aid?
317 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/09/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/09/1991 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	57,182	4,156		61,338	138	61,476		61,476			1
2	Food Purchase		34,263		34,263		34,263		34,263			2
3	Housekeeping	8,966	4,406		13,372	46	13,418		13,418			3
4	Laundry	1,457	1,718		3,175		3,175		3,175			4
5	Heat and Other Utilities			14,965	14,965		14,965	(1,304)	13,661			5
6	Maintenance	22,002	3,615	12,897	38,514	1,302	39,816	(95)	39,721			6
7	Other (specify):*											7
8	**TOTAL General Services**	89,607	48,158	27,862	165,627	1,486	167,113	(1,399)	165,714			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	274,338	24,089	12,940	311,367	649	312,016	(1,330)	310,686			10
10a	Therapy			100	100		100		100			10a
11	Activities	24,625	3,558	105	28,288		28,288		28,288			11
12	Social Services	32,579			32,579		32,579		32,579			12
13	Nurse Aide Training	5,100			5,100		5,100	4,000	9,100			13
14	Program Transportation		1,855		1,855		1,855		1,855			14
15	Other (specify):* DENTAL SERVICES			2,347	2,347		2,347		2,347			15
16	**TOTAL Health Care and Programs**	336,642	29,502	18,492	384,636	649	385,285	2,670	387,955			16
	C. General Administration											
17	Administrative			108,000	108,000		108,000	(32,572)	75,428			17
18	Directors Fees											18
19	Professional Services			11,001	11,001		11,001	415	11,416			19
20	Dues, Fees, Subscriptions & Promotions			2,785	2,785	375	3,160	103	3,263			20
21	Clerical & General Office Expenses	29,429	4,231	3,914	37,574		37,574	13,556	51,130			21
22	Employee Benefits & Payroll Taxes			68,687	68,687	(400)	68,287	15,710	83,997			22
23	Inservice Training & Education			441	441	(433)	8		8			23
24	Travel and Seminar			4,030	4,030	(375)	3,655	116	3,771			24
25	Other Admin. Staff Transportation							172	172			25
26	Insurance-Prop.Liab.Malpractice			10,240	10,240		10,240	174	10,414			26
27	Other (specify):*											27
28	**TOTAL General Administration**	29,429	4,231	209,098	242,758	(833)	241,925	(2,326)	239,599			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	455,678	81,891	255,452	793,021	1,302	794,323	(1,055)	793,268			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number S.T.R.I.V.E. #0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			38,490	38,490	(1,302)	37,188	665	37,853			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,355	21,355		21,355	427	21,782			32
33	Real Estate Taxes			3,000	3,000		3,000		3,000			33
34	Rent-Facility & Grounds			48,000	48,000		48,000		48,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			110,845	110,845	(1,302)	109,543	1,092	110,635			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,528	61,528		61,528		61,528			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			61,528	61,528		61,528		61,528			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	455,678	81,891	427,825	965,394		965,394	37	965,431			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,304)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(95)	6		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule EMPLOYEES @ OTHER SITES	(1,330)	10		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,729)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,766		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,766		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 37		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

S.T.R.I.V.E.

ID# 0036921

Report Period Beginning: 7/01/2003

Ending: 6/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	EMPLOYEES @ OTHER SITES	$ (1,330)	10	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,330)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,304)	0	0	0	0	0	0	0	0	0	0	(1,304)	5
6	Maintenance	(95)	0	0	0	0	0	0	0	0	0	0	(95)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,399)	0	0	0	0	0	0	0	0	0	0	(1,399)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,330)	0	0	0	0	0	0	0	0	0	0	(1,330)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	4,000	0	0	0	0	0	0	0	4,000	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,330)	0	0	4,000	0	0	0	0	0	0	0	2,670	16
	C. General Administration													
17	Administrative	0	0	0	(32,572)	0	0	0	0	0	0	0	(32,572)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	415	0	0	0	0	0	0	0	415	19
20	Fees, Subscriptions & Promotions	0	0	0	103	0	0	0	0	0	0	0	103	20
21	Clerical & General Office Expenses	0	0	12,902	654	0	0	0	0	0	0	0	13,556	21
22	Employee Benefits & Payroll Taxes	0	219	1,979	13,512	0	0	0	0	0	0	0	15,710	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	116	0	0	0	0	0	0	0	116	24
25	Other Admin. Staff Transportation	0	0	0	172	0	0	0	0	0	0	0	172	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	174	0	0	0	0	0	0	0	174	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	219	14,881	(17,426)	0	0	0	0	0	0	0	(2,326)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,729)	219	14,881	(13,426)	0	0	0	0	0	0	0	(1,055)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number S.T.R.I.V.E. # 0036921 **Report Period Beginning:** 7/01/2003 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	665	0	0	0	0	0	0	0	665	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	427	0	0	0	0	0	0	0	427	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	1,092	0	0	0	0	0	0	0	1,092	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,729)	219	14,881	(12,334)	0	0	0	0	0	0	0	37	45

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES	100%	BIG MEADOWS INC.	SAVANNA	LYNDON PROGRESS		DAY TREATMENT
	100	PLEASANT VIEW	MORRISON	CENTER	LYNDON	REHAB
MANAGEMENT ONLY	0	WINNING WHEELS, INC.	PROPHETSTOWN	LYNDON PLAY &		CHILD DAYCARE
				LEARN CENTER	LYNDON	
				FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	LIVING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	DAY CARE BENEFITS	$ 5,206	LYNDON PLAY & LEARN CENTER	100.00%	$ 5,425	$ 219	1
2	V		MANAGEMENT SERVICES	108,000	AMERICAN HEALTH ENTERPRISES	100.00%	95,666	(12,334)	2
3	V		ADMINISTRATIVE OVERHEAD		WINNING WHEELS, INC. (ADMINISTRATIVE FUND)	100.00%	14,881	14,881	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 113,206			$ 115,972	$ * 2,766	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21		$	WINNING WHEELS, INC.	100.00%	$ 12,902	$ 12,902	15
16	V	22			ADMINISTRATIVE FUND ALLOCATION	100.00%	1,979	1,979	16
17	V				(SEE DETAILS, SCHEDULE VIII B, PG 8)				17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 14,881	$ * 14,881	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 108,000	AMERICAN HEALTH ENTERPRISES, INC.	NONE	$ 79,428	$ (28,572)	15
16	V	22			AHE, INC.		13,512	13,512	16
17	V	19			(SEE DETAILS - SCHEDULE VII, PAGE 8)		415	415	17
18	V	20					46	46	18
19	V	21					654	654	19
20	V	24					116	116	20
21	V	25					172	172	21
22	V	26					174	174	22
23	V	30					665	665	23
24	V	32					427	427	24
25	V	20					57	57	25
26	V	17	HAB AIDE TRAINING FEES		RECLASS INSTRUCTIONAL PORTION		(4,000)	(4,000)	26
27	V	13	HAB AIDE TRAINING FEES				4,000	4,000	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 108,000			$ 95,666	$ * (12,334)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AMERICAN HEALTH ENTERPRISES, INC.		DIRECT						$		1
2	ALAN GAPINSKI	PRESIDENT	MANAGEMENT	100.00							2
3	(100% OWNER OF AMERICAN HEALTH ENTERPRISES, INC.)										3
4								MANAGEMENT FEES			4
5	S.T.R.I.V.E.			0.00	11,940	5	10.00	FEES	108,000	17,3	5
6	PLEASANT VIEW			100.00	23,880	10	20.00		115,210		6
7	BIG MEADOWS			100.00	33,432	14	28.00		150,317		7
8	WINNING WHEELS			0.00	42,984	18	36.00		174,000		8
9	OTHER (NON-REPORTING)			0.00	7,164	3	6.00		114,500		9
10											10
11											11
12											12
13								TOTAL	$ 662,027		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AMERICAN HEALTH ENTERPRISES, INC.
Street Address: 501 6TH AVENUE WEST
City / State / Zip Code: LYNDON, IL 61261
Phone Number: (815-778-3683
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 56,862	$ 56,862	1	$ 56,862	1
2	17	ADMINISTRATIVE	GROSS REVENUE	11,662,587	5	276,957	276,957	950,242	22,566	2
3	22	BENEFITS	DIRECT COST	541,122	1	92,052		79,428	13,512	3
4	19	PENSION FEES	GROSS REVENUE	11,662,587	5	1,213		950,242	99	4
5	19	DATA PROCESSING	GROSS REVENUE	11,662,587	5	2,723		950,242	222	5
6	19	ACCOUNTING	GROSS REVENUE	11,662,587	5	1,154		950,242	94	6
7	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	11,662,587	5	562		950,242	46	7
8	21	SUPPLIES, PHONE	GROSS REVENUE	11,662,587	5	8,032		950,242	654	8
9	24	TRAINING, SEMINARS	GROSS REVENUE	11,662,587	5	1,424		950,242	116	9
10	25	ADMIN. TRANSPORTAION	GROSS REVENUE	11,662,587	5	2,110		950,242	172	10
11	26	INSURANCE	GROSS REVENUE	11,662,587	5	2,139		950,242	174	11
12	30	DEPRECIATION VEHICLES	GROSS REVENUE	11,662,587	5	6,634		950,242	541	12
13	30	DEPRECIATION EQUIPMENT	GROSS REVENUE	11,662,587	5	1,519		950,242	124	13
14	32	INTEREST VEHICLES	GROSS REVENUE	11,662,587	5	5,237		950,242	427	14
15	20	RECRUITMENT	GROSS REVENUE	11,662,587	5	703		950,242	57	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 459,321	$ 333,819		$ 95,666	25

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WINNING WHEELS, INC.
Street Address: 501 6TH AVENUE WEST
City / State / Zip Code: LYNDON, IL 61261
Phone Number: (815-778-3610
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	ADMINISTRATIVE SALARIES	GROSS REVENUES	6,319,376	9	$ 84,214	$ 84,214	968,153	$ 12,902	1
2	22	FICA	GROSS REVENUES	6,319,376	9	5,844		968,153	895	2
3	22	Worker's Comp	GROSS REVENUES	6,319,376	9	252		968,153	39	3
4	22	Life Insurance	GROSS REVENUES	6,319,376	9	211		968,153	32	4
5	22	Health Insurance	GROSS REVENUES	6,319,376	9	2,913		968,153	446	5
6	22	Retirement	GROSS REVENUES	6,319,376	9	1,350		968,153	207	6
7	22	Dental Insurance	GROSS REVENUES	6,319,376	9	220		968,153	34	7
8	22	Disability Insurance	GROSS REVENUES	6,319,376	9	1,134		968,153	174	8
9	22	Child Care	GROSS REVENUES	6,319,376	9	993		968,153	152	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 97,131	$ 84,214		$ 14,881	25

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	IL HEALTH FACILITIES						$	$			$	1
2	FINANCING AUTHORITY		X	MORTGAGE	VARIES	11/29/90	381,000	158,000	8/15/2010	6.00-7.75	21,356	2
3												3
4	AMCORE BANK											4
5	HOME OFFICE ALLOCATION		X	VEHICLE	$624.50	1/2001	30,000		1/2006	9.0000	427	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$624.50		$ 411,000	$ 158,000			$ 21,783	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 411,000	$ 158,000			$ 21,783	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1,740	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	891	2
3. Under or (over) accrual (line 2 minus line 1).	$	(849)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	3,849	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	3,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	NONE	8
2000	NONE	9
2001	NONE	10
2002	604	11
2003	651	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME S.T.R.I.V.E. COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT ALAN GAPINSKI

TELEPHONE 815-778-3610 FAX #: 815-778-4503

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-04-176-013	THERAPY ANNEX	$ 236.24	$
2.	21-04-176-002	PARKING LOT	$ 127.28	$
3.	21-04-176-009	GARAGE	$ 287.24	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 650.76	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,022 B. General Construction Type: Exterior SIDING Frame WOOD/SPRINKLER Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1991	$ 10,207	1
2	GARAGE/PARKING		2995-2002	21,744	2
3	TOTALS			$ 31,951	3

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1991	$ 377,675	$ 9,442	40	$ 9,442	$	$ 124,690	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIDEWALK & PATIO			1992	2,578	64	40	64		781	9
10	CARPET			1992	1,690	29	10	29		1,690	10
11	EMERGENCY LIGHTING			1992	723	18	40	18		236	11
12	MIXING VALVES			1992	1,840	46	40	46		602	12
13	LANDSCAPING			1992	1,075	27	40	27		352	13
14	STORAGE SHED			1993	2,920	146	20	146		1,618	14
15	ROADWAY			1995	2,556	183	14	183		548	15
16	SIGN			1996	180	9	20	9		69	16
17	PAINTING			1996	1,625	163	10	163		1,232	17
18	CARPET			1997	621	62	10	62		471	18
19	LANDSCAPING			1997	520	52	10	52		394	19
20	CARPET			1997	4,575	457	10	457		3,470	20
21	GARAGE			1997	1,608	80	20	80		610	21
22	GARAGE			1997	36,165	1,447	25	1,447		9,885	22
23	SHOWER			1998	3,322	166	20	166		1,080	23
24	CARPET			1998	1,753		5			1,753	24
25	BATHROOM TILE & SHOWER			1999	5,386	539	10	539		2,424	25
26	SIDEWALK			2000	1,113	56	20	56		218	26
27	PARKING LOT			2000	4,972	497	10	497		1,823	27
28	FRONT HALLWAY			2001	5,817	291	20	291		751	28
29	STEPS & SIDEWALKS TO PARKING LOT			2002	4,770	238	20	238		556	29
30	REMODEL LOUNGE ENTRANCE			2002	46,157	2,307	20	2,307		4,616	30
31	RESIDENT ROOM CARPET			2002	3,982	569	7	569		853	31
32	CEMENT			2001	1,066	27	39	27		80	32
33	SIDEWALKS			2001	12,478	320	39	320		880	33
34	BEAUTIFICATION			2001	8,745	875	10	875		2,186	34
35	STEPS			2001	1,150	29	39	29		79	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DRAINAGE & GRADING	2001	$ 4,794	$ 240	20	$ 240	$	$ 619	37
38	SLIDING DOOR	2001	4,274	214	20	214		552	38
39	LEASEHOLD IMPROVEMENTS	2001	20,083	515	39	515		1,287	39
40	WINDOW SHADES & BLINDS	2001	3,629	518	7	518		1,296	40
41	CARPET	2001	14,041	2,006	7	2,006		5,015	41
42	FENCING	2001	1,334	89	15	89		185	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 585,217	$ 21,721		$ 21,721	$	$ 172,901	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 138,204	$ 15,337	$ 15,337	$		$ 88,709	71
72	Current Year Purchases	1,814	130	130			130	72
73	Fully Depreciated Assets	7,801					7,801	73
74	HOME OFFICE ALLOCATION			124	124			74
75	TOTALS	$ 147,819	$ 15,467	$ 15,591	$ 124		$ 96,640	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RECREATIONAL THERAP	92 DODGE VAN	1992	$ 31,845	$	$	$	5	$ 31,845	76
77										77
78	HOME OFFICE ALLOCATION					541	541			78
79										79
80	TOTALS			$ 31,845	$	$ 541	$ 541		$ 31,845	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 796,832	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,188	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,853	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 665	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 301,386	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: JAMES BIRKLEBAW

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	THERAPY							5
6	ANNEX	2001	NONE	12/2001	48,000	5	N/A	6
7	TOTAL				$ 48,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 12/2001
Ending 11/2006

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/2005	$ 48,000
13.	6/2006	$ 48,000
14.	/2007	$ 20,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)		1,700		1,700
4	Clinical Wages	(b)		3,400		3,400
5	In-House Trainer Wages	(c)			4,000	4,000
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 5,100	$ 4,000	$ 9,100
10	SUM OF line 9, col. 1 and 2	(e)	$ 5,100			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 250	$ 625,607	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12489/122554)	60,108	582,120	3
4	Supply Inventory (priced at COST)	8,589	42,330	4
5	Short-Term Investments		2,850,915	5
6	Prepaid Insurance	3,216	19,624	6
7	Other Prepaid Expenses	11,520	20,240	7
8	Accounts Receivable (owners or related parties)	145,312	1,699,312	8
9	Other(specify): Rent Deposit	8,000	597,063	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 236,995	$ 6,437,211	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		5,373	12
13	Land	31,951	282,861	13
14	Buildings, at Historical Cost	541,856	7,596,767	14
15	Leasehold Improvements, at Historical Cost	43,361	166,553	15
16	Equipment, at Historical Cost	179,664	2,104,412	16
17	Accumulated Depreciation (book methods)	(301,386)	(4,144,571)	17
18	Deferred Charges	3,560	4,835	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRESS		1,260	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 499,006	$ 6,017,490	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 736,001	$ 12,454,701	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 14,229	$ 140,076	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		172,969	29
30	Accrued Salaries Payable	33,947	249,361	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,741	12,563	31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,849	3,849	32
33	Accrued Interest Payable		1,342	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	BONDS PAYABLE	22,000	22,000	36
37	Due To/From Other Funds		1,699,312	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 75,766	$ 2,301,472	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,903,464	40
41	Bonds Payable	136,000	136,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	PA ADVANCE FOR DAY TREATMENT		49,029	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 136,000	$ 2,088,493	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 211,766	$ 4,389,965	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 524,235	$ 8,064,736	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 736,001	$ 12,454,701	48

*(See instructions.)

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 459,949	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 459,949	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	64,286	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 64,286	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 524,235	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,025,473	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,024,273	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	2,983	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,983	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**TRANSPORTATION**	999	28
28a	**MISC. INCOME - DETAIL ATTACHED**	1,425	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,424	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,029,680	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	165,627	31
32	Health Care	384,636	32
33	General Administration	242,758	33
	B. Capital Expense		
34	Ownership	110,845	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	61,528	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 965,394	40
41	**Income before Income Taxes (line 30 minus line 40)****	64,286	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 64,286	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	600	600	5,100	8.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,051	2,180	24,625	11.30	9
10	Activity Assistants					10
11	Social Service Workers	1,971	2,080	32,579	15.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,402	6,051	57,182	9.45	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,971	2,117	22,002	10.39	17
18	Housekeepers	1,146	1,281	8,966	7.00	18
19	Laundry	138	208	1,457	7.00	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,044	2,260	29,429	13.02	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	24,371	26,503	274,338	10.35	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	39,694	43,280	$ 455,678 *	$ 10.53	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	24	3,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	390	7,800	10,3	38
39	Pharmacist Consultant	12	480	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	5	105	11,3	44
45	Social Service Consultant				45
46	Other(specify) DENTIST	24	2,347	15,3	46
47	PSYCHOLOGICAL	1	100	10a,3	47
48	LAB	1	76	10,3	48
49	TOTAL (lines 35 - 48)	457	$ 13,908		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	372	4,584	10,3	52
53	TOTAL (lines 50 - 52)	372	$ 4,584		53

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNE DUNBAR	ADMINSTRATOR	0	$
(SALARY INCLUDED IN MANAGEMENT FEES-LINE 17, COL. 3)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 108,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 108,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CDW	COMPUTER UPGRADE	$ 313
JOHN PYSE	COMPUTER CONSULTANT	1,849
CREATIVE SOLUTIONS	MEDICAL RECORDS	2,709
MIDWEST AUTOMATED TIME	TIME CLOCK MAINT.	400
LCV	F/S AUDIT	5,730
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 11,001

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,671
Unemployment Compensation Insurance	
FICA Taxes	34,596
Employee Health Insurance	11,679
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	837
RETIREMENT	2,457
DISABILITY INSURANCE	5,540
PHYSICALS	109
CHILDCARE	5,578
EMPLOYEE MISC. BENEFITS	3,018
HOME OFFICE ALLOCATION	13,512
TOTAL (agree to Schedule V, line 22, col.8)	$ 83,997

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	57
Health Care Worker Background Check	
(Indicate # of checks performed)	
C.A.R.F.	1,280
SUBSCRIPTIONS	684
IHCA DUES	821
C.T.R.S. DUES	375
HOME OFFICE ALLOCATION	46
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,263

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,760
Seminar Expense	895
HOME OFFICE ALLOCATION	116
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,771

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING	7/2001	$ 1,206	5	$	$ 121	$ 241	$ 241	$ 241	$ 241	$ 121	$	$
2	PAINTING	9/2001	3,040	5		304	608	608	608	608	304		
3	PAINTING	6/2002	239	5		24	48	48	48	48	23		
4	PAINTING	6/2002	503	5		50	101	101	101	101	49		
5	PAINTING	8/2002	1,523	5			152	304	304	304	304	155	
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,511		$	$ 499	$ 1,150	$ 1,302	$ 1,302	$ 1,302	$ 801	$ 155	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **N0**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE ASSOC.-$821**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **6 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **867** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **61,528**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **LINDGREN,CALLIHAN, & VANOSDOL CPA'S** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

STATE OF ILLINOIS

Facility Name & ID Number S.T.R.I.V.E. # 0036921 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 250	$ 625,257	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12489/112054)	60,108	398,151	3
4	Supply Inventory (priced at COST)	8,589	40,360	4
5	Short-Term Investments		2,850,916	5
6	Prepaid Insurance	3,216	19,624	6
7	Other Prepaid Expenses	10,910	23,130	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ATTACHED	145,312	890,481	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 228,385	$ 4,847,919	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	31,951	194,451	13
14	Buildings, at Historical Cost	541,856	6,972,076	14
15	Leasehold Improvements, at Historical Cost	43,361	43,361	15
16	Equipment, at Historical Cost	179,664	1,683,618	16
17	Accumulated Depreciation (book methods)	(301,386)	(3,478,320)	17
18	Deferred Charges	3,560	4,835	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRESS		1,260	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 499,006	$ 5,421,281	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 727,391	$ 10,269,200	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 14,230	$ 118,353	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		172,969	29
30	Accrued Salaries Payable	33,946	199,275	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,741	10,136	31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,849	3,849	32
33	Accrued Interest Payable		1,342	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	BONDS PAYABLE	22,000	22,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 75,766	$ 527,924	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,903,464	40
41	Bonds Payable	136,000	136,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	RESERVE BOND FUND	(8,610)	(8,610)	43
44	PA ADVANCE FOR DAY TREATMENT		7,691	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 127,390	$ 2,038,545	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 203,156	$ 2,566,469	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 524,235	$ 7,702,731	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 727,391	$ 10,269,200	48

*(See instructions.)